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	175506	A. BUILDING _____ B. WING _____	12/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDBE HOME, INC	201 W CRANE ST NORTON, KS 67654

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: The facility had a census of 64 residents. The	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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sample included 20 residents. Based on observation, record review, and interview, the facility failed to notify the physician of altered vital signs for 3 of 20 sampled residents. Resident #52 and #28 had elevated blood pressures and Resident #75 had elevated pulse.

Findings included:

- Resident #75's 14 day (MDS) Minimum Data Set assessment, dated 11/3/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 13 which indicated intact cognition. The assessment revealed the resident required extensive assistance of 2 staff members for bed mobility, transfers, toileting, and personal hygiene. The assessment further revealed the resident had diagnoses of bimalleolar fracture of the ankle (fractured of the lower bones of the leg that help make up the ankle), (ALS) Amyotrophic lateral sclerosis, (a motor neuron disease), hypertension, (high blood pressure) dysphagia (difficulty or discomfort in swallowing) related to ALS, and generalized weakness (a decrease in the strength of one or more muscles).

The temporary care plan, dated 10/20/15, stated the resident will maintain hemodynamic (stable blood flow) stability as evidenced by stable vital signs.

The 10/23/15 physician standing orders stated when a pulse remains above 100 after rechecking the pulse in 15 minutes, contact the physician to ensure prompt response to the resident's change in condition and avoid delay in treatment.

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F 157	Continued From page 2 Review of the October 2015 vitals record revealed the resident had an elevated pulse outside of parameters and not reassessed per physician orders, for the following days: 10/23/15-106 10/26/15-106 10/27/15-115 10/28/15-103 10/30/15-102 Review of the November 2015 vitals record revealed the resident had an elevated pulse outside of parameters, and not reassessed per physician orders, for the following days: 11/2/15-114 11/3/15-102 On 12/15/15 at 11:00 AM, Licensed Nurse M verified the staff had not reassessed the resident after the resident had an elevated pulse and the physician had not been notified. On 12/16/15 1:57 PM, Administrative Nurse A stated nursing staff should reassess the resident's vital signs when they are outside of parameters. The 3/15/13 facility's When to Notify the Physician Policy stated when a pulse remains above 100 after recheck in 15 minutes, the nurse will contact the physician by phone, to ensure prompt response to a resident's change in condition, and avoid a delay in treatment. The facility failed to notify the physician, of Resident #75's outside parameter pulse on several occasions.	F 157		

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F 157	Continued From page 3 - Resident #28's physician order sheet, dated 10/29/15, indicated the resident had diagnoses of atherosclerotic heart disease (hardening and narrowing of blood vessels that deliver oxygen-rich blood from the heart to the tissues of the body), hyperlipidemia (a condition of elevated blood lipid levels), hypertension (elevated blood pressure), and atrial fibrillation (rapid, irregular heart beat). The quarterly (MDS) Minimum Data Set assessment, dated 9/7/15, indicated the resident had short and long term memory problems, moderately impaired cognitive skills for daily decision making, and required extensive assistance of 2 staff with (ADLs) Activities of Daily Living. The 9/7/15 care plan instructed staff to provide the resident extensive staff assistance with pivot transfers, with a gaitbelt, and a 2 wheeled walker for mobility. The care plan instructed staff to monitor the resident's mood and response to medication. The physician standing orders instructed staff to recheck the resident's blood pressure 15 minutes after obtaining a systolic (the amount of pressure that blood exerts on vessels while the heart is beating. In a blood pressure reading it is the number on the top) blood pressure above 170 or diastolic (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) blood pressure above 95. Review of the blood pressure log revealed the following:	F 157		

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On 12/4/15 at 10:22 PM the resident's blood pressure was 174/82, and no documentation the staff rechecked the resident's blood pressure.

On 12/5/15 at 7:18 AM the resident's blood pressure 173/83 and documentation the staff rechecked the resident's blood pressure at 3:49 PM. (8 hours and 31 minutes later)

On 12/15/15 at at 7:05 AM the resident's blood pressure 184/83, and documentation the staff rechecked the resident's blood pressure at 11:53 AM. (3 hours and 48 minutes later)

On 12/15/15 at 3:09 PM, observation revealed the resident seated quietly, in a recliner, in his/her room, with his/her eyes open.

On 12/15/15 at 3:11 PM, Nurse B stated if the resident's blood pressure is higher then the parameters on the physician standing order, he/she would recheck the resident's blood pressure in 15 minutes, and if still not within the parameters, would notify the physician.

On 12/16/15 at 2:37 PM, Administrative Nurse A stated staff should follow the physician standing order regarding the resident's blood pressure.

The facility's 12/14/15 physician standing orders instructed staff to recheck the resident's blood pressure 15 minutes after obtaining a systolic (the amount of pressure that blood exerts on vessels while the heart is beating. In a blood pressure reading it is the number on the top) blood pressure above 170 or diastolic (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) blood pressure above 95.

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The facility failed to notify the physician when Resident #28 had blood pressures outside parameters readings, on 3 separate occasions.

- Resident #52's quarterly (MDS) Minimum Data Sheet assessment, dated 11/2/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 7 which indicates severe cognitive impairment. The assessment revealed the resident required limited assistance for bed mobility, transfers, walking, locomotion on unit, dressing, toileting, and personal hygiene.

The 11/2/15 care plan directed staff to encourage the resident to slowly assume a standing position and monitor for anticholinergic (a substance that blocks the passage of impulses through the nerves) effects.

The 6/11/15 physician's order on admission directed staff to administer Doxazosin (high blood pressure medication) 2 (mg) milligrams daily to the resident.

The 7/26/15 physician's order directed staff to check the resident's blood pressure daily.

The 9/7/15 physician's order directed staff to administer Coreg (high blood pressure medication) 25 mg BID (two times a day) to the resident.

The 10/5/15 physician's order directed staff to administer Accupril (high blood pressure medication) 40 mg daily at 5:30 PM 20 mg daily at 8:00 AM to the resident.

The October vital signs record revealed the resident's following blood pressure:

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F 157	Continued From page 6 -10/12/15 at 7:00 AM was 172/87. The medical record had no documentation the staff rechecked the resident's blood pressure or notified the physician. -10/16/15 at 6:50 AM, was 178/100. The medical record had no documentation the staff rechecked the resident's blood pressure until 10:02 AM (over 3 hours later) with a reading of 161/82, and not after 15 minutes, as directed in the facility's vital sign parameters protocol, or notified the physician. The November vital signs record revealed the resident's following blood pressure: -11/19/15 at 8:05 AM was 171/75. The medical record had no documentation the staff rechecked the resident's blood pressure until 9:29 AM (1 and ½ hours later) with a reading of 127/62, or notified the physician. The December vital signs record revealed the resident's following blood pressure: -12/5/15 at 6:37 AM was 197/94. The medical record revealed staff rechecked the resident's blood pressure at 7:06 AM (30 minutes later) with a reading of 188/94. The medical record revealed staff rechecked the blood pressure (2 hours later) at 9:16 AM with a reading of 128/69. The staff had not notified the physician. On 12/14/15 at 9:30 AM, observation revealed the resident seated in his/her recliner using a nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs), and smiling.	F 157		

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F 157	Continued From page 7 On 12/16/15 2:30 PM Administrative Nurse A stated he/she had expected the staff to recheck the resident's blood pressures after 15 minutes as per the facility's vital signs parameters protocol. The facility's vital sign parameters protocol directed staff to contact the physician if the resident's systolic (the highest arterial blood pressure of a cardiac cycle) blood pressure was above 170 or if the diastolic (the arterial pressure during the interval between heartbeats) blood pressure was above 95, after recheck in 15 minutes. The facility failed to seek physician guidance for Resident #52, who had elevated blood pressures.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225		

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F 225	Continued From page 8 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 20 residents. Based on observation, record review and interview, the facility failed to thoroughly report and investigate a fall with injury to the state agency for Resident #42 and #71, and a resident to resident altercation involving Resident #40. Findings included: - Resident #42's diagnoses from the 11/01/2015 physician's progress notes included anxiety (a feeling of worry, nervousness, or unease), depression (a state of feeling sad, hopeless, and unimportant), alzheimer's (a progressive mental deterioration, due to generalized degeneration of the brain, that results in a loss of memory, thinking, and language skills). The significant change (MDS) Minimum Data Set	F 225		

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assessment, dated 8/10/2015, indicated the resident had a short and long term memory loss and severely impaired cognition. The assessment revealed the resident required extensive assistance of 2 staff for transfers, bed mobility, dressing and personal hygiene. The assessment further revealed the resident had unsteady balance, no upper impairment and one side lower extremity impairment, and had no falls.

The 9/08/2014 fall care plan stated the resident was a high risk for falls, and directed the staff to monitor the resident at all times, provide 30 minute safety checks, and keep the call light within reach at all times. The care plan directed the staff to provide non skid foot wear and reminders to the resident as needed.

The 11/26/2014 fall assessment was at 19.0 and indicated the resident was a risk for falls.

The 12/26/2014 at 9:10 AM, nurse's notes revealed the staff heard the resident hollering "help". The notes stated the staff ran down to the resident's room and found him/her sitting on the floor, his/her back leaning against the bedside table, and he/she crying. The notes stated the resident was not able to tell the staff what had happened due to his/her diagnosis of Alzheimer's Disease. The notes stated the resident had a 2 (cm) centimeter skin tear on his/her left elbow, and a 0.5 cm skin tear on his/her right middle finger. The notes indicated the resident hollered out his/her left hip hurt and the nurse noted the left leg had external rotation. The notes indicated the staff notified the resident's physician and family and then (EMS) Emergency Medical

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F 225	Continued From page 10 Services transported the resident to the hospital emergency room for evaluation. The 12/26/2014 at 10:00 AM, nurse's note stated the staff received a call from the hospital and confirmed the resident had a left hip fracture. The hospital transferred the resident to an out of town hospital for hip surgery. On 12/15/2015 at 10:45 AM, observation revealed the resident, seated in a broda (tilted recliner, multi positional wheelchair), in the living room. The resident had a pressure alarm attached to the back of the chair and to his/her shirt. On 12/15/2015 at 3:15 PM, Administrative Nurse A stated the resident had an unwitnessed fall on 12/26/2014 that resulted in a left fractured hip and a skin tear to his/her right middle finger and left elbow. Administrative Nurse A verified the fall was not called into the state agency. On 12/16/2015 at 8:45 AM, Licensed Nurse O stated the resident had been in his/her room, and the staff heard him/her holler for help. Observation revealed the resident fell out of his/her bed and was on the floor. License Nurse O stated most of the resident's on the special care unit are a fall risk, wander throughout the unit, and have a diagnosis of Alzheimer's and /or dementia, which makes them at risk for impaired judgement. The facility's 4/18/2013 Abuse Policy stated the residents have the right to be free from verbal,	F 225		

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F 225	Continued From page 11 sexual, physical, and mental abuse, corporal punishment, neglect, and involuntary seclusion. The resident must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy stated all suspicious injuries or injuries of unknown origin are to be investigated and documented, all patterns or trends revealed by the Quality Assurance log are to be investigated and acted upon as appropriate. The policy stated all allegations of abuse, neglect, or exploitation are investigated and reported immediately to the Administrator and to KDADS (Kansas department of Aging and Disabilities). If abuse is suspected, the facility will investigate and document all violations and shall take appropriate measures to prevent further potential abuse, neglect or exploitation. The facility failed to report and thoroughly investigate cognitively impaired Resident #42's unwitnessed fall, resulting in a fractured hip, and skin tears. - Resident #71's admission (MDS) Minimum Data Set assessment, dated 9/21/15, indicated the resident had a (BIMS) Brief Interview of Mental Status score of 3 which indicated severely impaired cognition. The assessment revealed the resident required extensive assistance of 1 staff	F 225		

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member for transfers, ambulation in room, toileting, and limited assistance for ambulation in the corridor. The assessment further revealed the resident unsteady, used a cane, no functional impairment, and had 1 fall with injury.

The 9/15/15 care plan stated the resident used a cane and 1 staff member for ambulation and directed staff to assist the resident with toileting every 2 hours before and after meals, and at bedtime. The 9/24/15 updated care plan directed staff to ensure the resident had a personal alarm on at all times and staff placed the resident on 30 minute safety checks.
The 9/20/15 at 10:19 PM, nurse's note stated the resident had an unwitnessed fall in his/her room and obtained a 6 (cm) centimeter laceration (cut) on the top of his/her head. The note further stated the resident was taken to a local hospital for sutures (stitches).

The 9/20/15 at 10:41 PM, investigation report stated the resident had an unwitnessed fall in his/her room and obtained a laceration to the back of his/her head and required sutures.

The 10/14/15 at 12:20 AM, nurse's note stated the resident had an unwitnessed fall in his/her room and obtained a superficial (shallow) 5.5 cm skin tear to the back of his/her head. The resident had gotten his/her feet tangled in a quilt.

The 10/14/15 at 1:52 AM, investigation report stated the resident had been sleeping in his/her recliner and had gotten his/her feet tangled in a quilt. The report stated staff had the resident's family pick up the quilt.

On 12/14/15 at 3:02 PM, Nurse Aide N stated the resident required 1 staff to assist him/her with

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ambulation.

On 12/14/15 at 3:15 PM, Licensed Nurse T stated the resident was confused and required 1 person assistance with ambulation. Licensed Nurse T further stated after the falls the resident was moved to a room closer to the nurse's station, 30 minute safety checks, and had a personal alarm, but still tried to get up unassisted.

On 12/15/15 at 2:00 PM, Administrative Nurse A verified he/she did not report the unwitnessed falls to the state agency.

The 4/18/13 facility's Abuse Policy stated the residents have the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, neglect, and involuntary seclusion. The resident must not be subjected to abuse by anyone, including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The policy further stated all allegations of abuse, neglect are investigated immediately and reported to the Administrator and to KDADS (Kansas Department of Aging and Disability Services).

The facility failed to report cognitively impaired Resident #71's falls, which were unwitnessed and resulted in injury.

- Resident #40's medical record revealed the following diagnoses from the 11/16/15 signed physician's orders: dementia with behavioral disturbance (a loss of brain function that occurs with certain diseases, affecting memory, thinking, language, judgement, and behavior) and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 14 Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). The quarterly (MDS) Minimum Data Set, dated 11/9/15, indicated the resident scored 5, on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment. The MDS indicated the resident required extensive assistance of 1 staff with bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene, and supervision with set up help only for eating. The MDS further indicated the resident did not have any physical or verbal behavioral symptoms directed towards others, but did have other behavioral symptoms not directed at others on one to three days during the assessment period. The 3/5/15 Behavioral Symptoms (CAA) Care Area Assessment stated the resident regularly yelled out at night, yelled inappropriate things, and called staff names. The CAA further stated staff attempted to redirect the resident's behavior by providing snacks, moving him/her to the nurse's station to prevent disturbing other residents, and staff would continue to monitor and document behavioral symptoms. The 11/9/15 care plan instructed staff to attempt to keep the resident's routine consistent and to encourage involvement in activities. The care plan lacked staff direction for the resident's behavioral symptoms. The 9/18/15 fax from the psychiatric nurse practitioner directed staff there were no changes to the resident's medications, set limits on inappropriate behaviors, and schedule a follow up visit in one month.	F 225		

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The 10/1/15 at 10:15 AM nurse's note stated the resident kicked another resident in the right leg. The staff redirected the resident with a 1:1 visit on being kind to others.

The 10/9/15 at 2:20 PM physician's order stated to change the resident's antidepressant medication from daily to every other day for five doses then discontinue and the physician would review in two weeks.

The 10/10/15 at 4:20 PM nurse's note stated the resident kicked another resident and staff separated them. The nurse's note continued that the resident stated "I can kick him/her if I feel like it." The staff informed the resident that was inappropriate and directed the resident to use his/her call light if someone threatened him/her. The nurse's note stated the resident was 1:1 with staff when in proximity to the other resident (The resident had severe cognitive impairment as identified by the 11/9/15 MDS).

On 12/10/15 at 3:04 PM observation revealed the resident sleeping in a recliner with a personal alarm attached to his/her shirt. The call light was clipped to the recliner next to the resident's hand. The resident was dressed appropriately for the season and had non-skid shoes on.

On 12/15/15 at 8:38 AM, observation revealed two staff members transferred the resident from his/her wheelchair to the recliner using a gait belt and his/her walker. The staff performed the transfer without difficulty, provided for privacy, and the resident tolerated the transfer without any abnormal behaviors.

On 12/14/15 at 2:13 PM, Nurse Aide P stated the

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resident had not displayed any physical aggression that he/she had ever witnessed.

On 12/14/15 at 8:40 AM, Nurse Aide H stated he/she had never witnessed the resident hit or kick another resident. Nurse Aide H further stated if he/she witnessed a resident to resident altercation, he/she would separate the residents and report it to the charge nurse.

On 12/15/15 at 9:49 AM, Nurse B stated he/she has never witnessed a resident to resident altercation, but he/she knows the resident and another resident don't get along well, so staff keep them separated as much as possible. Nurse B stated if he/she did witness a resident to resident altercation, he/she would split the residents up and report the incident to the director of nursing.

On 12/16/15 at 2:00 PM, Administrative Nurse A verified the resident to resident altercations on 10/1/15 and 10/10/15 had not been reported to the state agency. Administrative Nurse A stated after a resident to resident altercation, the nursing staff assess the residents to ensure that no injuries occurred.

The 4/18/13 Abuse policy stated residents have the right to be free from verbal, sexual, physical and mental abuse. The policy further stated to prevent abuse from residents to other residents, staff will attempt to maintain a quiet environment, quiet music may be played at intervals, touch therapy with lotion may be used on a resident that is exhibiting inappropriate behavior and other interventions will be used as appropriate. The policy also stated residents needs or behaviors that might lead to abuse or neglect are identified and addressed on the care plan and the facility

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F 225	Continued From page 17 will ensure that all allegations of abuse, neglect, or exploitation are investigated and reported immediately to the administrator of the facility and to the appropriate state agency. The facility failed to report two resident to resident altercations involving cognitively impaired Resident #40, to the appropriate state agency.	F 225		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This Requirement is not met as evidenced by: The facility had a census of 64 residents of which 8 residents resided on the central part of the north hall. Based on observation, record review and interview the facility failed to provide a safe environment to maintain a comfortable temperature in the building in 2 of 8 residents who resided in the facility, on 1 of 3 halls. Findings included: - On 12/9/15 at 3:33 PM, during stage 1 process, Resident #65 stated his/her room is always cold in the morning. On 12/09/2015 at 4:28 PM, during stage 1 process, Resident #37's family member stated the resident's room is always cold, he/she had asked staff to turn the heat up on several different occasions, and staff never seems to turned it up. On 12/15/2015 at 11:00 AM, during the	F 257		

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F 257	Continued From page 18 environmental tour of the facility observation revealed the following room temperatures on the North hall: Resident #37's room 62.9 degrees Resident #63's room 66.7 degrees Dining room 67.9 degrees Mechanical room 42 degrees On 12/15/2015 at 11:15 AM, observation revealed Maintenance Staff U removed the ceiling air flow vents from the north dining room and from Resident #37 and #63's rooms, and no air flow coming out of the vents. Maintenance Staff U verified he/she knew a lot about plumbing but lacked knowledge when it came to heating and air conditioning. On 12/15/15 at 11:30 AM, observation revealed, when checking temperatures of the other 6 resident's rooms, on the north hall, temperatures were above 70 degrees. On 12/15/2015 at 4:20 PM, tour of the North hall with Heating and Air Condition Technician V revealed the thermostats for the rooms on the North hall were located on the adjacent hall, half way down the hall and blowing directly on the thermostat which was reading 78 degrees. The technician stated the location of the thermostat gave an inaccurate reading of the actual hall temperature and the thermostats needed to be zoned to accurately provide the correct temperature on the resident room and hall. The technician stated in the North dining room and in Resident #37 and #63's rooms there is no air flow coming out of the vents.	F 257		

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F 257	Continued From page 19 The facility lacked a preventative maintenance policy to maintain adequate room temperatures. The facility failed to maintain safe comfortable temperatures for residents residing in the facility, on the North Hall.	F 257		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 20 residents of which 2 were reviewed for behavioral issues. Based on observation, record review, and interview the facility failed to develop a comprehensive care plan, for behavioral issues for 1 of 2 residents reviewed for behavioral issues (#40).	F 279		

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- Resident #40's medical record revealed the following diagnoses from the 11/16/15 signed physician's orders: dementia with behavioral disturbance (a loss of brain function that occurs with certain diseases, affecting memory, thinking, language, judgement, and behavior) and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions).

The quarterly (MDS) Minimum Data Set, dated 11/9/15, indicated the resident scored 5, on the (BIMS) Brief Interview for Mental Status, which indicated severe cognitive impairment. The MDS indicated the resident required extensive assistance of 1 staff with bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene, and supervision with set up help only for eating. The MDS further indicated the resident did not have any physical or verbal behavioral symptoms directed towards others, but did have other behavioral symptoms not directed at others on one to three days during the assessment period.

The 3/5/15 Behavioral Symptoms (CAA) Care Area Assessment stated the resident regularly yelled out at night, yelled inappropriate things, and called staff names. The CAA further stated staff attempted to redirect the resident's behavior by providing snacks, moving him/her to the nurse's station to prevent disturbing other residents, and staff would continue to monitor and document behavioral symptoms. The CAA indicated the resident's care plan would address behavioral symptoms.

The 11/9/15 care plan instructed staff to attempt to keep the resident's routine consistent and to encourage involvement in activities. The care

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plan lacked staff direction for the resident's behavioral symptoms.

The 9/18/15 fax from the psychiatric nurse practitioner directed staff there were no changes to the resident's medications, set limits on inappropriate behaviors, and schedule a follow up visit in one month.

The 10/1/15 at 10:15 AM nurse's note stated the resident kicked another resident in the right leg. The staff redirected the resident with a 1:1 visit on being kind to others.

The 10/9/15 2:20 PM physician's order stated to change the resident's antidepressant medication from daily to every other day for five doses then discontinue and the physician would review in two weeks.

The 10/10/15 at 4:20 PM nurse's note stated the resident kicked another resident and staff separated them. The nurse's note continued that the resident stated "I can kick him/her if I feel like it." Staff informed the resident that was inappropriate and directed the resident to use his/her call light if someone threatened him/her. The nurse's note stated the resident was 1:1 with staff when in proximity to the other resident.

The 12/14/15 at 9:42 PM nurse's note stated the resident's alarm went off several times during the shift and when asked by staff what he/she needed, the resident responded he/she needed his/her car.

On 12/10/15 at 3:04 PM observation revealed the resident sleeping in a recliner with a personal alarm attached to his/her shirt. The resident appropriately dressed for the season with

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non-skid shoes on, and a call light clipped to the recliner next to the resident's hand.

On 12/15/15 at 8:38 AM, observation revealed two staff members assisted the resident from his/her wheelchair to the recliner using a gait belt and his/her walker. The staff performed the transfer without difficulty, provided for privacy, and the resident tolerated the transfer without any abnormal behaviors.

On 12/14/15 at 2:13 PM, Nurse Aide P stated the resident had not displayed any physical aggression that he/she had ever witnessed. Nurse Aide P stated the resident sleeps most of the day and was more awake at night and the resident sometimes would call out "help me." When staff asked what he/she needed, the resident would respond, "I just wanted to see how fast you can run."

On 12/15/15 at 4:05 PM, Administrative Nurse S verified the resident did have behavioral symptoms and no care plan for management of his/her behaviors.

On 12/16/15 at 2:00 PM, Administrative Nurse A stated he/she would expect the resident's care plan to address behavioral symptoms.

The 4/18/13 Abuse policy stated resident's needs or behaviors that might lead to abuse or neglect are identified and addressed on the care plan. The 4/18/13 Resident Care Plan policy stated the staff reevaluated and revised the care plan to meet the resident's needs every 90 days and the care plan reflects standards of current professional practice by use of the (RAI) Resident Assessment Instrument. Subjective and objective data that implies a problem, need or strength of a

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F 279	Continued From page 23 resident is gathered and listed on the resident care plan. Each problem or need is dated, numbered and identified by a discipline. The problem or need is followed by a measurable goal and approaches necessary to obtain the desired outcome. The facility failed to develop a comprehensive care plan to address behavioral symptoms for Resident #40.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 20 residents. Based on observation, record review and interview, the facility failed to reassess blood pressure, for 2 sampled resident's #52, #28, and Resident #75's elevated pulse, per the physician standing orders. Findings included: - Resident #75's 5 day (MDS) Minimum Data Set assessment, dated 11/3/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 13 which indicated intact cognition. The assessment revealed the resident required extensive assistance of 2 staff members for bed mobility, transfers, toileting, and personal	F 309		

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hygiene. The assessment further revealed the resident had diagnoses of bimalleolar fracture of the ankle (fractured of the lower bones of the leg that help make up the ankle), (ALS) Amyotrophic lateral sclerosis, (a motor neuron disease), hypertension, (high blood pressure) dysphagia (difficulty or discomfort in swallowing) related to ALS, and generalized weakness (a decrease in the strength of one or more muscles).

The temporary care plan, dated 10/20/15, stated the resident will maintain hemodynamic (blood flow) stability as evidenced by stable vital signs.

The 10/23/15 physician standing orders stated when a pulse remains above 100 after rechecking the pulse in 15 minutes, contact the physician to ensure prompt response to the residents change in condition and avoid delay in treatment.

Review of the October 2015 vitals record revealed the resident had an elevated pulse outside of parameters and not reassessed per physician orders, for the following days:
10/23/15-106
10/26/15-106
10/27/15-115
10/28/15-103
10/30/15-102

Review of the November 2015 vitals record revealed the resident had an elevated pulse outside of parameters, and not reassessed per physician orders, for the following days:
11/2/15-114
11/3/15-102

On 12/15/15 at 11:00 AM, Licensed Nurse M verified the staff did not reassess the resident

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F 309	Continued From page 25 after the resident had an elevated pulse. On 12/16/15 1:57 PM, Administrative Nurse A stated nursing staff should reassess the resident's vital signs when outside of parameters. The facility's vital sign parameters protocol directed staff to contact the physician if the resident ' s systolic (the highest arterial blood pressure of a cardiac cycle) blood pressure was above 170 or if the diastolic (the arterial pressure during the interval between heartbeats) blood pressure was above 95, after recheck in 15 minutes. The facility failed to reassess,as set by the physician, Resident #75, after having several incidents of an outside parameter pulse. - Resident #28's physician order sheet, dated 10/29/15, indicated the resident had diagnoses of atherosclerotic heart disease (hardening and narrowing of blood vessels that deliver oxygen-rich blood from the heart to the tissues of the body), hyperlipidemia (a condition of elevated blood lipid levels), hypertension (elevated blood pressure), and atrial fibrillation (rapid, irregular heart beat). The quarterly (MDS) Minimum Data Set assessment, dated 9/7/15, indicated the resident had short and long term memory problems, moderately impaired cognitive skills for daily decision making, and required extensive assistance of 2 staff with (ADLs) Activities of Daily Living.	F 309		

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F 309	Continued From page 26 The 9/7/15 care plan instructed staff to provide the resident extensive staff assistance with pivot transfers, with a gaitbelt, and a 2 wheeled walker for mobility. The care plan instructed staff to monitor the resident's mood and response to medication. The physician standing orders instructed staff to recheck the resident's blood pressure 15 minutes after obtaining a systolic (the amount of pressure that blood exerts on vessels while the heart is beating. In a blood pressure reading it is the number on the top) blood pressure above 170 or diastolic (minimum level of blood pressure measured between contractions of the heart; the bottom number of a blood pressure reading) blood pressure above 95. Review of the blood pressure log revealed the following: On 12/4/15 at 10:22 PM the resident's blood pressure was 174/82, and no documentation the staff rechecked the resident's blood pressure. On 12/5/15 at 7:18 AM the resident's blood pressure 173/83 and documentation the staff rechecked the resident's blood pressure at 3:49 PM. (8 hours and 31 minutes later) On 12/15/15 at at 7:05 AM the resident's blood pressure 184/83, and documentation the staff rechecked the resident's blood pressure at 11:53 AM. (3 hours and 48 minutes later) On 12/15/15 at 3:09 PM, observation revealed the resident seated quietly, in a recliner, in his/her room, with his/her eyes open. On 12/15/15 at 3:11 PM, Nurse B stated if the resident's blood pressure is higher then the	F 309		

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parameters on the physician standing order, he/she would recheck the resident's blood pressure in 15 minutes, and if still not within the parameters, would notify the physician.

On 12/16/15 at 2:37 PM, Administrative Nurse A stated staff should follow the physician standing order regarding the resident's blood pressure.

The facility's vital sign parameter protocol directed staff to contact the physician if the resident's systolic (the highest arterial blood pressure of a cardiac cycle) blood pressure was above 170 or if the diastolic (the arterial pressure during the interval between heartbeats) blood pressure was above 95, after recheck in 15 minutes.

The facility failed to monitor and reassess blood pressures for Resident #28, who had outside parameter readings, on 3 separate occasions, without staff reassessing the blood pressure 15 minutes after each abnormal reading, as physician ordered.

- Resident #52's quarterly (MDS) Minimum Data Sheet assessment, dated 11/2/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 7, which revealed a severe cognitive impairment. The assessment revealed the resident required limited assistance for bed mobility, transfers, walking, locomotion on unit, dressing, toileting, and personal hygiene.

The 11/2/15 care plan directed staff to encourage the resident to slowly assume a standing position and monitor for anticholinergic (a substance that blocks the passage of impulses through the nerves) effects.

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F 309	Continued From page 28 The 6/11/15 physician's order on admission directed staff to administer Doxazosin (high blood pressure medication) 2 (mg) milligrams daily to the resident. The 7/26/15 physician's order directed staff to check the resident's blood pressure daily. The 9/7/15 physician's order directed staff to administer Coreg (high blood pressure medication) 25 mg BID (two times a day) to the resident. The 10/5/15 physician's order directed staff to administer Accupril (high blood pressure medication) 40 mg daily at 5:30 PM and 20 mg daily at 8:00 AM to the resident. The October vital signs record revealed the resident's following blood pressure: -10/12/15 at 7:00 AM was 172/87. The medical record had no documentation the staff rechecked the resident's blood pressure or notified the physician. -10/16/15 at 6:50 AM was 178/100. The medical record had no documentation the staff rechecked the resident's blood pressure until 10:02 AM (over 3 hours later) with a reading of 161/82, and not after 15 minutes as directed by the facility's vital sign parameters protocol, or notified the physician. The November vital signs record revealed the resident's following blood pressure: -11/19/15 at 8:05 AM was 171/75. The medical record had no documentation the staff rechecked	F 309		

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F 309	Continued From page 29 the resident's blood pressure until 9:29 AM (1 and ½ hours later) with a reading of 127/62, or notified the physician. The December vital signs record revealed the resident's following blood pressure: -12/5/15 at 6:37 AM was 197/94. The medical record revealed staff rechecked the resident's blood pressure at 7:06 AM (30 minutes later) with a reading of 188/94. The medical record revealed staff rechecked the blood pressure (2 hours later) at 9:16 AM with a reading of 128/69. The staff had not notified the physician. On 12/14/15 at 9:30 AM, observation revealed the resident seated in his/her recliner using a nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs), and smiling. On 12/16/15 2:30 PM Administrative Nurse A stated he/she had expected the staff to recheck the resident's blood pressures after 15 minutes as per the facility's vital sign parameters protocol. The facility's vital sign parameters protocol directed staff to contact the physician if the resident's systolic (the highest arterial blood pressure of a cardiac cycle) blood pressure was above 170 or if the diastolic (the arterial pressure during the interval between heartbeats) blood pressure was above 95, after recheck in 15 minutes. The facility failed to thoroughly assess and monitor Resident #52, who had elevated blood pressures.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

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F 325	Continued From page 30 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 20 residents of which 5 were reviewed for nutrition. Based on observation, record review, and interview the facility failed to maintain acceptable parameters of nutritional status for 2 of 5 residents (#40, #65). Findings included: - Resident #40's medical record revealed the following diagnoses from the 11/16/15 signed physician's orders: dementia with behavioral disturbance (a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgement, and behavior), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), edema (a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body), constipation, history of falling, muscle weakness, hypertension (high blood pressure) and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).	F 325		

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The quarterly (MDS) Minimum Data Set assessment, dated 11/9/15, indicated the resident scored 5, on the (BIMS) Brief Interview for Mental Status, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required extensive assistance of 1 staff with bed mobility, transfers, walking, locomotion, dressing, toilet use and personal hygiene and supervision with set up help only for eating. The MDS further indicated the resident weighed 208 pounds and received a regular diet.

The nutritional (CAA) Care Area Assessment, dated 3/5/15, indicated the resident was independent with eating and received a regular diet. The CAA further indicated the resident weighed 225 pounds.

The care plan, dated 11/9/15, indicated the resident received a regular diet, texture as tolerated with no skin, seeds, or hulls, and the resident preferred a full meal during the night. The care plan directed the dietary staff to leave a full meal in the refrigerator for the nursing staff to heat up at night. The care plan further directed the staff to weigh the resident weekly, ensure the resident's plate is set up, and provide prompting to eat as necessary.

The medical record revealed a diet order, dated 5/10/13, for frequent small meals and a snack three times daily, between meals, at 10:00 AM, 3:00 PM, and 8:00 PM.

The (RD) Registered Dietician progress note, dated 3/12/15, indicated the resident's current weight was 223.5 pounds, his/her weight had fluctuated slightly but remained within a 5 pound range. At bedtime, he/she received a large snack to help meet the resident's nutritional needs and if

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there was further weight loss another intervention would be added to prevent additional weight loss.

The RD progress note, dated 5/14/15, indicated the resident's current weight was 217.5 pounds. The progress note further revealed staff would proceed with the current interventions and closely monitor the resident's weight.

The RD progress note, dated 8/13/15, indicated the resident's current weight was 213 pounds and there had been a 10 pound decrease over the past three months. The progress note revealed the resident's oral intake continued to be very poor and the RD recommended a milk shake in the afternoon to help prevent further weight loss.

The RD progress note, dated 11/12/15, indicated the resident's current weight was 207 pounds, a 5 pound weight loss over the past few months, and the RD recommended the resident would benefit from a food snack in the afternoon to help prevent further weight loss.

The 11/9/15 Quarterly Nutrition Assessment completed by the (CDM) Certified Dietary Manager indicated the resident's weight was 209 pounds, he/she received a regular diet with no skins, seeds, or hulls; texture as tolerated and supplements as needed. The assessment further indicated that the resident received supplemental foods of small meals, protein snacks between meals, and a nighttime meal if the resident was hungry during those hours.

The Nutritional History Form, completed by the RD on 4/30/13, identified the resident's total caloric needs, estimated protein needs and estimated fluid needs but the record lacked documentation the RD ever reassessed the

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resident.

The weight record revealed the following:
6/16/15-216.5#
9/10/15-212.5#
11/10/15-207#
12/8/15-203.5#
12/10/15-202#

The September 2015 food intake record revealed 3:00 PM snack intake documentation for 9/15/15 and 9/18/15 (2 of 30 days).

The October 2015 food intake record revealed bedtime snack and 3:00 PM snack intake documentation for 10/2/15, 10/6/15, 10/8/15, 10/15/15, 10/17/15, 10/18/15, 10/20/15, 10/21/15, 10/23/15, 10/27/15, 10/31/15 (11 of 31 days).

The November 2015 food intake record revealed bedtime and 3:00 PM snack intake documentation for 11/4/15, 11/10/15, 11/13/15, 11/18/15 (4 of 30 days).

The December food intake record through 12/15/15, revealed bedtime and 3:00 PM snack intake documentation for 12/9/15 (1 of 15 days).

All intake records for the snacks indicated 76-100% consumption and lacked documentation the resident refused any snacks.

On 12/14/15 at 12:45 PM, observation revealed the resident seated in his/her wheelchair at the dining room table with his/her eyes closed, with food and fluids on the dining room table in front of the resident. Further observation revealed staff prompted the resident on two occasions, the resident briefly opened his/her eyes, and displayed no other response. Observation

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revealed the resident did not eat any of his/her lunch meal.

On 12/15/15 at 7:37 AM, observation revealed the resident, seated in his/her wheelchair at the dining room table, awake and wearing oxygen. The resident had a bowl of oatmeal, without anything on it, and three glasses of fluids on the table. At 7:39 AM, dietary staff served the resident a plate with plain toast, butter on the side in packages, sausage links, and eggs. Observation further revealed the resident dozed briefly, picked up a glass and took a drink, then dozed again. At 7:47 AM the resident took off his/her oxygen and clothing protector and called out " help. " A staff member came to place the oxygen in the bag on the oxygen concentrator and helped the resident place his/her clothing protector on the table. At 7:55 AM, the resident independently started to feed himself/herself, eating less than 25% of the breakfast meal. Continued observation revealed the resident dozing again at 8:13 AM, while seated at the dining room table.

On 12/15/15 at 9:50 AM, Nurse B stated the resident is able to eat independently and sometimes needs verbal prompting by staff. Nurse B further stated that breakfast and daytime in general was not the resident's best time of day and there are always snacks available for the resident to eat during nighttime hours. Nurse B verified the nurse aide staff are to document in the record, the percentage of meals and snacks the resident consumes, as well as refusals of food.

On 12/15/15 at 3:00 PM, Nurse Aide C stated the resident does not get a scheduled afternoon snack. Nurse Aide C further stated the staff often

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offers the resident an afternoon snack of graham crackers or vanilla wafers but the resident is not consistent and does not always want a snack. Nurse Aide C stated the resident does get a scheduled bedtime snack.

On 12/16/15 at 12:05 PM, Dietary Manager D stated the resident does not get any scheduled snacks, but the dietary staff kept pot pies in the freezer for the resident to eat at night. Dietary Manager D further stated when the RD made recommendations for a resident, the RD told Dietary Manager D so the interventions could be put into place. In regards to the RD's recommendations for the resident, made on 11/12/15, Dietary Manager D stated the RD didn't write down the recommendations for the resident in the communication notebook the staff used. Dietary Manager D verified the resident was not getting his/her ordered diet of frequent small meals and snack, three times daily, between meals, at 10:00 AM, 3:00 PM, and 8:00 PM.

On 12/16/15 at 2:00 PM, Administrative Nurse A stated that he/she knows the resident often refuses daytime and afternoon snacks and he/she does not monitor if the residents are getting their ordered diets. Administrative Nurse A was not aware the resident was not receiving his/her ordered diet and the RD's recommendations were not being followed.

The facility's 7/18/13 Significant Weight Loss policy stated the RD will review approaches taken for adequate nutrition for each individual on a monthly basis and appropriate nutritional interventions will be provided as necessary to include high protein supplements, snacks and other dietary/nursing measures to avoid further weight loss.

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F 325	Continued From page 36 The facility's 4/19/13 Aide Charting policy instructed staff to record each time nourishment is offered, accepted or refused, and the amount consumed. The facility failed to maintain acceptable parameters of nutritional status for Resident #40, who lost 14.5 pounds in the past six months. - Resident #65's quarterly (MDS) Minimum Data Set assessment, dated 12/7/15, indicated the resident had a (BIMS) Brief Inventory for Mental Status score of 8, which indicated moderately impaired cognition. The MDS indicated the resident required limited staff assistance with (ADLs) Activities of Daily Living except independent with eating. The MDS indicated the resident had no swallowing problems, height of 55 inches, weighed 112 lbs, no weight loss, and had no dental problems. The 12/7/15 care plan indicated the resident wore loose fitting upper/lower dentures, ate independently, and instructed staff to serve to the resident a regular diet, texture as tolerated, and keep snacks in the resident's room. The care plan instructed staff to administer to the resident, 120 (cc) cubic centimeters of med plus (a high calorie, high protein supplement), three times a day, and a supplemental shake one time daily. The 9/10/15 at 10:28 AM Registered Dietician note indicated on admission date 6/30/2015, the resident weighed 121.5 lbs, current weight 114 and had been stable the past few months. The note indicated the resident consumed 50-75% of his/her meals, he/she would monitor the	F 325		

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resident's weight, and instructed staff to continue with the same approaches.

The 12/1/15 at 11:49 AM physician order instructed staff to administer, to the resident, 120 cc of med plus three times a day with meals and to change the 3:00 PM nutritional shake to 10 AM.

The 12/10/15 at 10:43 AM dietary manager note indicated the resident's currently weighed 112 lbs, had lost 2 lbs, and consumed 50 to 75% of meals. The note indicated staff provided the resident with medplus three times a day, with meals, and a nutritional shake daily.

Review of the vital flow sheet revealed from 12/1 to 12/15/15, no documentation staff provided the physician ordered nutritional shake at 10:00 AM.

On 12/15/15 at 10:58 AM, observation revealed Nurse Aide I did not pass the resident his/her shake.

On 12/15/15 at 10:58 AM, Nurse Aide I stated he/she did not have a shake for the resident on the snack cart, and stated sometimes the kitchen does not send one. Nurse Aide I stated if the resident does not have a nutritional shake on the snack cart, he/she does not receive one.

On 12/15/15 at 1:23 PM, Dietary Manager D stated the resident should receive a shake every day at 10:00 AM.

On 12/15/15 at 1:26 PM, Dietary Staff Q stated he/she must have removed and discarded the resident's nutritional shake by mistake this AM.

On 12/15/15 at 2:46 PM Nurse R stated the aides

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F 325	Continued From page 38 document the resident's intake of his/her daily nutritional shake. On 12/16/15 at 2:37 PM, Administrative Nurse A stated dietary staff should send a sheet, on the snack cart with the residents' names, type of snack to serve each resident, and if the snack is not on the cart, the aide should check with dietary to see why it was excluded. Administrative Nurse A stated the resident should receive his/her nutritional shake on a regular basis and staff should document the amount consumed. The facility's 4/19/13 Aide Charting policy stated the nurse aide is to document extra nourishment taken by the resident, time offered, accepted or refused, and the amount. The facility failed to maintain acceptable parameters of nutritional status, such as body weight, by not providing a system for administering and tracking Resident # 65's physician ordered nutritional shake.	F 325		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 20 residents of which 3 were reviewed for hydration. Based on observation, record review and interview, the facility failed to provide adequate fluids and monitor hydration status for 3 of the 3 sampled residents. (#75, #42, #40) #75 admitted to the hospital with a diagnosis	F 327		

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of dehydration.

Findings included:

- Resident #75's medical record revealed the facility admitted the resident into skilled nursing on 10/20/15.

The resident's (POS) physician's order sheet, dated 10/20/15, revealed the resident had diagnoses of left ankle fracture, (ALS) Amyotrophic lateral sclerosis, (a motor neuron disease), night hypoxia (deficiency in the amount of oxygen reaching body tissues), dysphagia (difficulty or discomfort in swallowing) related to ALS, and generalized weakness (a decrease in the strength of one or more muscles).

The 5 day Medicare (MDS) Minimum Data Set assessment, dated 10/27/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 13 which indicated intact cognition. The assessment revealed the resident required extensive assistance of 2 staff for bed mobility, transfers, personal hygiene, and independent with supervision for eating. The assessment further revealed the resident had a functional impairment of the lower extremity on 1 side, and received speech, occupational, and physical therapy 5 days a week. The assessment did not indicate the resident's type of diet.

The 14 day MDS, dated 11/3/15, indicated the resident had a BIMS of 13 which indicated intact cognition. The assessment revealed the resident remained the same except was on a mechanically altered diet.

The Nutritional (CAA) Care Area Assessment, dated 11/2/15, indicated the resident had a

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diagnosis of ALS which affected his/her swallowing food and fluids. The CAA further indicated the resident's fluid daily totals were 700-800 (ml) milliliters.

The 10/20/15 temporary care plan directed staff to provide fresh water of thin consistency, three times a day, encourage adequate fluid intake, and notify the physician of significant changes. The 10/29/15 updated care plan stated the staff planned to talk with the resident's primary physician regarding the resident's request for a feeding tube.

Review of the medical record lacked an (RD) Registered Dietician's nutritional assessment to direct staff of the estimated fluid needs of the resident from his/her admission to the facility to the present.

A general guideline for determining baseline daily fluids is to multiply the resident's body weight in kilograms and times by 30 cc. The resident's admission weight was 239 pounds, therefore the resident required 3240 cc of fluid per day to prevent dehydration.

Review of the facility's fluid intake record from 10/20/15 through 10/29/15, when the physician assistant evaluated the resident, revealed the following daily fluid intake:
10/20/15- 540 (ml) milliliters
10/21/15- 680 ml
10/22/15- 740 ml
10/23/15- 870 ml
10/24/15- 10 ml
10/25/15- 670 ml
10/26/15- 770 ml
10/27/15- 430 ml
10/28/15- 840 ml

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F 327	Continued From page 41 10/29/15- 350 ml Review of the urine output record revealed the resident had urine output on 10/21/15 and 10/23/15 but lacked documentation of any other days the resident had any output from 10/24/15 to 11/3/15. The 10/13/15 hospital laboratory report, prior to admission, revealed the resident's (CMP) comprehensive metabolic panel (a blood test that serves as a initial broad medical screening tool) was within normal limits. The 10/22/15 at 2:12 PM, nurse's note indicated the resident would take sips of water between small bites of food. The 10/23/15 at 9:44 PM, nurse's note stated the resident complained of his/her spit going down his/her throat, and gagging him/her after a coughing spell. The note further stated the staff notified the physician but received no new orders. The 10/27/17 fax communication to the physician stated the resident had a resting heart rate of 115 (normal 60-100). (The fax lacked documentation of the resident's decreased daily fluid intake) The 10/28/15 laboratory report revealed the resident's chloride level of 98, (normal 100-116), carbon dioxide 33, (normal is 18-29), creatinine 0.49, (normal 0.6-1.3), and calcium 11.20 (normal 8.60 - 10.40). The 10/28/15 untimed, speech therapy note stated the resident was very tired and had no energy. The note further stated the resident had possible thrush (white, cottage cheese appearance) on his/her tongue and the therapist reported it to nursing staff. (The medical record	F 327		

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lacked documentation staff notified the physician or completed any other assessment of the resident)

The 10/28/15 untimed, physical therapy note stated the resident had a resting heart rate of 117 (bpm) beats per minute during the therapy session.

The 10/29/15 untimed, speech therapy note indicated the resident's spouse stated the physician assistant would talk to the resident's primary care physician regarding a feeding tube for extra nutrition but would wait until the resident had seen an ear, nose and throat specialist the following week.

The 10/29/15 physician assistants' notes indicated the resident had slightly dry oral mucosa and difficulty swallowing fluids due to a lot of thick phlegm and stated he/she would be talking with the resident's primary care physician regarding a feeding tube. The note further stated he/she would order Mucinex ER, (an expectorant that thins mucus and sputum) 600 (mg) milligrams), twice a day, to help with secretions.

Review of the facility's fluid intake record from 10/30/15 to 11/3/15 revealed the following daily fluid intake:
10/30/15-360 ml
10/31/15-220 ml
11/1/15-240 ml
11/2/15-330 ml
11/3/15-150 ml

The 10/31/15 at 8:18 PM, nurse's note stated the resident refused all food and had taken only sips of liquid that shift, due to extreme dysphagia and fear of aspiration (choking).

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F 327	Continued From page 43 The 11/2/15 untimed, speech therapy note stated the resident seemed pale and exhausted, and nursing staff reported the resident had consumed 240 ml of fluid in the last 24 hours. The note further stated the resident's resting heart rate was 114 (bpm) beats per minute and the therapist reported to nursing staff the concern of possible dehydration. The note further stated staff would fax the physician. The 11/2/15 at 1:33 PM, fax communication to the physician stated the resident had a resting heart rate of 114 which increased with movement and exercise. The note stated the resident had lost 11 pounds in 10 days but lacked any mention of the resident's fluid status. The physician stated insertion of a feeding tube was being arranged. Review of the medical record lack documentation any further assessment completed for the resident. The 11/2/15 untimed, physical therapy note stated the resident had a heart rate of 110-114 bpm, and required several rest breaks due to fatigue and shortness of breath. The note stated he/she limited the resident's exercises due to the resident's high heart rate. The physical therapist voiced concern to nursing staff of the resident's heart rate and dehydration, weight loss, decreased oxygen level. The note stated the physician assistant was to consult with the resident's primary care physician regarding a feeding tube but there had not been any new orders. The note further stated the therapist voiced concern over the resident traveling for an appointment the next day due to the resident's declining condition. The 11/3/15 untimed, physical therapy note stated	F 327		

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the therapist talked with the charge nurse and stated the resident needed to be seen by a physician due to dehydration, and high resting heart rate. The note stated the therapist met with the director of nursing and indicated the resident required hospitalization with (IV) intravenous fluids. The note stated the director of nursing would contact the primary care physician regarding his/her concerns with the resident. The note later stated the resident would be admitted to a local hospital later in the afternoon.

The 11/3/15 untimed, speech therapy note stated the resident was pale and exhausted with a resting heart rate of 125. The note further stated the resident's tongue had a coating and very dry lips. The note stated the speech therapist had the resident swab his/her mouth with a toothette and put chapstick on his/her lips. The note stated the therapist spoke with nursing staff about the concern for dehydration, high heart rate, no energy, and always tired. The note further stated the nursing staff had notified the physician and the plan was to put in a feeding tube on 12/6/15.

The 11/3/15 History and Physical from the local hospital stated the resident had difficulty swallowing and had not taken any solid food for 4 days, additionally, he/she choked easily even though nursing staff tried thickening his/her liquids. The H & P further stated the resident would be admitted due to dehydration and for IV fluids as his/her oral mucosa was dry and his/her calcium level was high at 12 (normal 8.60-10.40) due to dehydration. (Review of the medical record lacked documentation the staff thickened the resident's liquids)

The resident did not return to the facility after his/her hospital admission.

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F 327	Continued From page 45 On 12/14/15 at 3:03 PM, Nurse Aide N stated the resident needed total care for all activities of daily living. Nurse Aide N stated the staff documented all fluid intakes into the computer. On 12/14/15 at 4:00 PM, Dietary Manager D stated the dietician had not assessed the resident and the speech therapist had directed the dietary staff to mechanically alter the resident's diet. Dietary Manager D stated he/she did not monitor the resident's fluids. On 12/15/15 at 8:36 AM, Social Service Staff I stated he/she had taken the resident to his/her appointment out of state on 11/3/15. Social Service Staff I further stated the resident's spouse went along to the appointment and they had stopped several times on the way back because the resident was uncomfortable from the long drive due to sitting up for an extended time. Social Service Staff I stated the hospital admitted the resident to the local hospital for fluids after they returned. On 12/5/15 at 11:00 AM, Licensed Nurse M stated staff tried to encourage the resident to eat and drink, and even used tomato juice in his/her foods. Licensed Nurse M further stated the resident did not look dehydrated, and verified the staff did not monitor the resident's fluid intake. On 12/15/15 at 2:30 PM, Registered Dietician L stated he/she came to the facility once a month and relied on the dietary manager to tell him/her if any residents were at risk. Registered Dietician L further stated he/she did not assess the resident while at the facility. On 12/16/15 at 10:30 AM, Physician J stated	F 327		

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he/she was unsure how often the facility notified him/her of the resident's hydration status. Physician J further stated it might have made a difference in the outcome if the resident would have been admitted sooner to the hospital but could not say that for sure.

On 12/16/15 at 1:57 PM, Administrative Nurse A stated the nursing staff should have monitored the resident' s fluid intake and documented any contact made to the physician notifying him/her of the resident's hydration status and increased heart rate. Administrative Nurse A further stated he/she was aware of the resident's risk for dehydration due to ALS and thought the facility could take care of the resident. Administrative Nurse A stated, although it was not documented, the resident should have received at least 1,000 ml of fluid daily.

The 5/5/99 facility's Fluid Encouragement Policy stated the facility should provide fluid intake based on individual needs to prevent dehydration. The policy directed staff to be gentle, be persistent, and encourage the resident to take adequate fluids and to offer fluids frequently.

The facility failed to monitor, and assess Resident #75, who showed signs of dehydration and required hospitalization.
- Resident #42's significant change (MDS) Minimum Data Set assessment, dated 8/10/2015, indicated the resident had short and long term memory loss and severely impaired cognition. The assessment revealed the resident required extensive assistance of 2 staff for eating, transfers, bed mobility, dressing, toilet use and personal hygiene. The assessment further revealed the resident received a mechanically altered diet.

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F 327	Continued From page 47 The 11/02/2015 care plan directed the staff to assist the resident and encourage good meal intake. The care plan indicated the resident received a regular pureed diet, appetite had declined, and he/she was no longer able to independently eat or drink. The care plan directed the staff to monitor the resident for signs and symptoms of dehydration, thirst, poor skin turgor, dry skin/mucous membranes, concentrated/decreased urine output, elevated heart rate, constipation, increase in falls, and sudden mental changes. On 12/10/2015 at 12:00 PM, observation revealed the resident seated in a broda chair in the special care unit dining room. Observation revealed the resident pursed his/her lips together and frowned when Nurse Aide W attempted to assist him/her to eat a spoonful of pureed food. Further observation revealed the Nurse Aide W placed his/her right hand around the back of the resident's neck and pulled him/her forward to sit the resident up straight, Nurse Aide W and assisted the resident to drink the beverages from a cup, the resident pursed his/her lips together and drank a small amount of fluid, and some ran out of his/her mouth. Continued observation revealed the resident had cracked, dry peeling lips. The 11/04/2015 Certified Dietary Managers nutritional notes indicated the resident received a regular pureed diet and a supplemental shake 1 time a day for weight maintenance. The notes indicated the resident's food intake was 76-100%, and fluid intake was approximately 1287 (cc) cubic centimeters.	F 327		

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F 327	Continued From page 48 A general guideline for determining baseline daily fluids is to multiply the resident's body weight in kilograms and times by 30 cc. The resident weight was 138 pounds, therefore the resident required 1875 cc of fluid per day to prevent dehydration. Review of the medical records revealed the following intakes: 12/02/15- 980 12/04/15- 780 12/05/15- 720 12/07/15- 940 12/08/15- 720 12/09/15- 900 12/11/15- 840 The medical record revealed no documentation of a nutritional assessment by a registered dietician in the last year to indicate the resident's nutritional needs including calories, proteins, and fluids. On 12/15/2015 at 2:40 PM, Registered Dietician L stated the Certified Dietary Manager would do a dietary evaluation after the resident's admission to the facility, and he/she would complete his/her dietary evaluation within 30 days of the resident's admission. On 12/15/2015 at 3:00 PM, Dietary Manager D stated he/she completed the resident's initial dietary evaluation and if he/she determined the resident was at risk he/she would contact Registered Dietician L. Dietary Manager D was unable to provide the survey team a list of the criteria for a resident at risk. On 12/15/2015 at 3:15 PM, Administrative Nurse	F 327		

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A verified the certified dietary manager would complete the initial dietary evaluation to include height, weight, and the diet ordered when the facility admitted the resident. Administrative Nurse A verified the Registered Dietician only comes to the facility once a month to do the dietary assessments for new admissions, review the residents with weight loss, and residents at risk. Administrative Nurse A was unable to provide a criteria for a resident at risk and when the registered dietician should be contacted with a new admit.

The facility's 5/05/1999 fluid encouragement policy indicated the purpose is to provide fluid intake based on the resident's individual needs, to prevent dehydration, and to provide nutrition. The assessment would include hydration status, difficulty chewing and swallowing, nutritional status, hand dexterity, reason for fluid refusal, need for dietary and fluid restriction's food preference, food allergies or dislikes, need for assistive devices, congestion, pain condition of mouth and teeth, shortness of breath and edema and skin turgor. The sign and symptoms include dry skin and/or mucous membranes, cracked lips, poor skin turgor, thirst and fever. The staff would position the resident in Fowler's (the upper half of the resident's body is 60 and 90 degrees in relation to the lower half of his/her body.) Have the fluids at the proper temperature, be gentle, be persistent and encourage the resident to take adequate fluids and offer fluids frequently. The policy states to record date, time, amount and types of fluid taken, if indicated. Record the amount of the resident's cooperation and encouragement needed.

The facility failed to ensure the provision and monitoring of sufficient fluid intake to maintain

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proper hydration for Resident #42.
- Resident #40's medical record revealed the following diagnoses from the 11/16/15 signed physician's orders: dementia with behavioral disturbance (a loss of brain function that occurs with certain diseases, affecting memory, thinking, language, judgement, and behavior), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), edema (a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body), constipation, history of falling, muscle weakness, hypertension (high blood pressure) and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).
The quarterly (MDS) Minimum Data Set, dated 11/9/15, indicated the resident scored 5, on the (BIMS) Brief Interview for Mental Status, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required extensive assistance of 1 staff with bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene, and supervision with set up help only for eating. The MDS further indicated the resident weighed 208 pounds and received a regular diet.
The nutritional (CAA) Care Area Assessment, dated 3/5/15, indicated the resident eats independently in the main dining room, and dietary assessments and dietician reviews would be completed quarterly and as needed. The dehydration and fluid maintenance CAA did not trigger.
The care plan, dated 11/9/15, instructed staff to encourage adequate fluid intake, monitor and report any signs/symptoms of dehydration (thirst, pallor, elevated heart rate, constipation, increase in falls, change in mental status, decreased urinary output or concentrated urine, dry skin/mucous membranes, fever, abnormal lab

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values, postural hypotension), weigh the resident weekly, ensure the resident's plate is set up, and provide prompting to eat as necessary.
The medical record revealed the most recent Nutritional History Form completed by the (RD) Registered Dietician, on 4/30/13, identified the resident's total caloric needs, estimated protein needs and estimated fluid needs (2 ½ years ago).
Review of the facility's intake record for December 1st through 15th, 2015 revealed the following total daily fluid intake:
12/1/15- 900 (ml) milliliters
12/2/15- 610 ml
12/3/15- 835 ml
12/4/14- 870 ml
12/5/15- 990 ml
12/6/15- 660 ml
12/7/15- 930 ml
12/8/15- 135 ml
12/9/15- 210 ml
12/10/15- 880 ml
12/11/15- 580 ml
12/12/15- 725 ml
12/13/15- 445 ml
12/14/15- 565 ml
12/15/15- 835 ml
Review of the facility's urinary output record for December 1st through 15th, 2015 revealed the following: on 12/5/15, 12/6/15, and 12/7/15 the record lacked documentation for urinary output for the resident. On 12/9/15 the record indicated the resident had urinary output twice. On 12/12/15 the record indicated the resident had urinary output 3 times. For all other days the record indicated the resident had urinary output once per day.
On 12/14/15 at 12:45 PM, observation revealed the resident, seated in his/her wheelchair at the dining room table with his/her eyes closed and food and fluids placed on the dining room table in

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front of the resident. Further observation revealed staff prompted him/her on two occasions in which the resident briefly opened his/her eyes and made no further response. The resident did not eat any of his/her lunch meal.
On 12/15/15 at 8:38 AM, observation revealed two staff members transferred the resident from his/her wheelchair to the recliner, approximately 8 feet away from his/her dresser where the water pitcher was placed, outside of the resident's reach.
On 12/14/15 at 8:40 AM, Nurse Aide H stated the resident usually eats fairly well but he/she didn't eat well that morning. Nurse Aide H further stated the resident gets food at night when he/she is awake, the resident eats better during the night and the resident doesn't prefer water but does like to drink coffee.
On 12/15/15 at 9:50 AM, Nurse B stated the resident is able to eat independently and sometimes needs verbal prompting by staff. Nurse B further stated that breakfast and daytime in general was not the resident's best time of day and there are always snacks available for the resident to eat during nighttime hours. Nurse B verified the nurse aide staff are to document in the record, the percentage of meals and snacks the resident consumes, the amount of fluids the resident drinks, as well as refusals of food and fluids.
On 12/16/15 at 2:00 PM, Administrative Nurse A stated that he/she knows the resident often refuses daytime and afternoon snacks and nursing staff monitors for dehydration. Administrative Nurse A verified nurse aide staff are to document each time a resident has urinary output, and stated as a general rule, residents should receive 1,000 (ml) milliliters per day.
The facility's 4/19/13 Aide Charting policy instructed staff to record each time nourishment

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F 327	Continued From page 53 is offered, accepted or refused, and the amount consumed. The facility's 5/5/1999 Fluid Encouragement policy instructed staff to be gentle, be persistent and encourage the resident to take adequate fluids, to offer fluids frequently, and to record the date, time, amount and type of fluid taken. The facility failed to ensure Resident #40 had sufficient fluid intake to maintain proper hydration and health.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by:	F 329		

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F 329	Continued From page 54 The facility had a census of 64 residents. The sample included 20 residents of which 5 were reviewed for unnecessary medication. Based on observation, record review, and interview, the facility failed to ensure unnecessary drug use , including duplicate blood pressure medication use for 1 of 5 sampled residents. (#52). Finding included: Resident #52's quarterly (MDS) Minimum Data Sheet assessment, dated 11/2/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 7 which indicated severe cognitive impairment. The assessment revealed the resident required limited assistance for bed mobility, transfers, walking, locomotion on unit, dressing, toileting, and personal hygiene. The 11/2/15 care plan directed staff to encourage the resident to slowly assume a standing position and monitor for anticholinergic (a substance that blocks the passage of impulses through the nerves) effects. The 6/11/15 physician's order on admission directed staff to administer Doxazosin, (high blood pressure medication) 2 (mg) milligrams, daily, to the resident. The 7/26/15 physician's order directed staff to check the resident's blood pressure daily. The 9/7/15 physician's order directed staff to administer Coreg, (high blood pressure medication) 25 mg, BID (two times a day) to the resident. The 10/5/15 physician's order directed staff to administer Accupril, (high blood pressure medication) 40 mg, daily at 5:30 PM and 20 mg	F 329		

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F 329	Continued From page 55 daily at 8:00 AM to the resident. The medical record revealed the following BPs (Blood Pressures): December: range 128-197/69-94 November: range 110-172/70-89 October: range 138-178/71-100 The facility's vital sign parameters protocol directed staff to contact the physician if the resident's systolic (the highest arterial blood pressure of a cardiac cycle) blood pressure was above 170 or if the diastolic (the arterial pressure during the interval between heartbeats) blood pressure was above 95, after recheck in 15 minutes,. The October vital signs record revealed the resident's following blood pressure: -10/12/15 at 7:00 AM was 172/87. The medical record had no documentation the staff rechecked the resident's blood pressure or notified the physician. -10/16/15 at 6:50 AM, was 178/100. The medical record had no documentation the staff rechecked the resident's blood pressure until 10:02 AM (over 3 hours later) with a reading of 161/82, and not after 15 minutes, as directed by the facility's vital sign parameters, or notified the physician. The November vital signs record revealed the resident's blood pressure: -11/19/15 at 8:05 AM was 171/75. The medical record had no documentation the staff rechecked the resident's blood pressure until 9:29 AM (1 and ½ hours later) with a reading of 127/62, or notified the physician.	F 329		

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F 329	Continued From page 56	F 329		

The December vital signs record revealed the resident's blood pressure:
-12/5/15 at 6:37 AM was 197/94. The medical record revealed staff rechecked the resident's blood pressure at 7:06 AM (30 minutes later) with a reading of 188/94. The medical record revealed staff rechecked the blood pressure (2 hours later) at 9:16 AM with a reading of 128/69. The staff had not notified the physician.

Review of the resident's medical record revealed no documentation of specific interventions or reassessment of the resident each time the resident had elevated blood pressures outside of the Vital Signs Parameters Protocol.

The 6/6/15 fax to the physician asked the physician to review BMP (Basic Metabolic Panel) and CBC (Complete Blood Count) blood lab results. Currently takes Accupril, 20 mg, BID (two times a day), Coreg, 25 mg, BID, and Doxazosin, 2 mg, daily.

On 6/6/15, the faxed Physicians response stated - No changes.

The 12/22/15 fax from Administrative Nurse A stated that the pharmacy did not address the blood pressure medications.

On 12/22/15 at 8:25 AM, Administrative Nurse A stated that the resident was taking all three blood pressure medications because the physician was having problems regulating the resident's blood pressure. Administrative Nurse A further stated the physician ordered all three medications for the resident's blood pressure. The facility has Physicians orders for all three medications.

The facility failed to ensure unnecessary drug use

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F 329	Continued From page 57 including duplicate blood pressure medication use for Resident #52.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility had a census of 64 residents. The sample included 20 residents. Based on observation, record review and interview, the facility failed to prepare, store, distribute and serve food under sanitary conditions for the 64 residents in the facility, who receive their meals from 1 of 1 facility kitchen. - On 12/09/2015 at 2:00 PM, observation of the kitchen revealed the tile floor with dirt and brown/black buildup along the floor and the baseboard. On 12/10/2015 at 12:00 PM, observation of meal service revealed an overhead ceiling fan above the food preparation area. Further observation revealed brown dust/lint on the top of the fan blades and on the ceiling above the fan. On 12/10/2015 at 12:45 PM, observation of the kitchen revealed an over head exhaust vent above the dishwasher area. Further observation	F 371		

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F 371	Continued From page 58 revealed brown/gray lint in the exterior cover of the vent and around the ceiling area. The kitchen florescent overhead lighting between the food preparation area and the dishwashing area, and in the storage area, revealed brown specks in the light covers resembling bugs. On 12/10/2015 at 12:50 PM, Dietary Staff D verified the debris on the floor, the lint on the fan and dishwasher exhaust vent, and the florescent lights with debris and stated there is a daily, weekly and monthly cleaning schedule to clean the areas. Review of the 3/23/2000 facility kitchen cleaning schedule revealed the staff are to mop the floor daily. The cleaning schedule revealed the staff would clean the ceiling fans weekly, and the hood and filters about the cooking area and grates in the ceiling, monthly. The facility failed to prepare and serve food under sanitary conditions for the 64 residents who resided in the facility and received meals from the facility kitchen.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 59	F 428		

This Requirement is not met as evidenced by:
The facility had a census of 64 residents. The sample included 20 residents of which 5 were reviewed for unnecessary medication. Based on observation, record review, and interview, the facility's pharmacy consult failed to identify and address 1 of 5 sampled residents, who received multiple blood pressure medications. (#52)

Finding included:

Resident #52's quarterly (MDS) Minimum Data Sheet assessment, dated 11/2/15, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 7 which revealed indicates severe cognitive impairment. The assessment revealed the resident required limited assistance for bed mobility, transfers, walking, locomotion on unit, dressing, toileting, and personal hygiene.

The 11/2/15 care plan directed staff to encourage the resident to slowly assume a standing position and monitor for anticholinergic (a substance that blocks the passage of impulses through the nerves) effects.

The 6/11/15 physician's order on admission directed staff to administer Doxazosin (high blood pressure medication) 2 (mg) milligrams daily to the resident.

The 7/26/15 physician's order directed staff to check the resident's blood pressure daily.

The 9/7/15 physician's order directed staff to administer Coreg (high blood pressure medication) 25 mg BID (two times a day) to the resident.

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F 428	Continued From page 60 The 10/5/15 physician's order directed staff to administer Accupril (high blood pressure medication) 40 mg daily at 5:30 PM and 20 mg daily at 8:00 AM to the resident. The facility's pharmacist consultant review revealed the following: 11/4/14 - no concerns 12/2/14 - no concerns 1/5/15 seroquel 12.5 HS (hour of sleep) RVB (risk verses benefit) - 1/9/15 pharmacist reviewed seroquel. No changes per Physician Z. 2/2/15 - no concerns 3/1/15 - zyretc RVB - 3/4/15 Recommendation from pharmacist consultant to DC zyrtec. Reviewed by Physician Z with no change at this time. Noted Worse off meds. 4/6/15 - no concerns 5/3/15 - seroquel 25HS RVB - 5/6/15 Fax received no change. State requests a note of benefit and continued need: paranoid without med. per Physician Z. 6/1/15 - no concerns 7/6/15 - no concerns 8/3/15 - no concerns 9/8/15 - zoloft 100RVB -9/11/15 Pharmacy consultant recommendation received. Physician X agrees to a trial decrease of zoloft to 50 mg X 2 weeks and review. 10/5/15 - no concerns 11/2/15 - seroquel 25HS RVB - 11/9/15 Pharmacy consult recommendation for received. Nurse Practitioner Y does not wish to change seroquel at this time. Continue. at 25 mg every HS.	F 428		

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F 428	Continued From page 61 12/1/15 - no concerns The medical record revealed the following BPs (Blood Pressures): December: range 128-197/69-94 November: range 110-172/70-89 October: range 138-178/71-100 The facility's vital sign parameters protocol directed staff to contact the physician if the resident's systolic (the highest arterial blood pressure of a cardiac cycle) blood pressure was above 170 or if the diastolic (the arterial pressure during the interval between heartbeats) blood pressure was above 95, after recheck in 15 minutes. The October vital signs record revealed the resident's following blood pressure: -10/12/15 at 7:00 AM was 172/87. The medical record had no documentation the staff rechecked the resident's blood pressure or notified the physician. -10/16/15 at 6:50 AM, was 178/100. The medical record had no documentation the staff rechecked the resident's blood pressure until 10:02 AM (over 3 hours later) with a reading of 161/82, and not after 15 minutes, as directed by the facility's vital sign parameters, or notified the physician. The November vital signs record revealed the resident's blood pressure: -11/19/15 at 8:05 AM was 171/75. The medical record had no documentation the staff rechecked the resident's blood pressure until 9:29 AM (1 and ½ hours later) with a reading of 127/62, or notified the physician.	F 428		

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F 428	Continued From page 62 The December vital signs record revealed the resident's blood pressure: -12/5/15 at 6:37 AM was 197/94. The medical record revealed staff rechecked the resident's blood pressure at 7:06 AM (30 minutes later) with a reading of 188/94. The medical record revealed staff rechecked the blood pressure (2 hours later) at 9:16 AM with a reading of 128/69. The staff had not notified the physician. Review of the resident's medical record revealed no documentation of specific interventions or reassessment of the resident each time the resident had elevated blood pressures outside of the Vital Signs Parameters Protocol. The 6/6/15 fax to the physician asked the physician to review BMP (Basic Metobolic Panel) and CBC (Complete Blood Count) blood lab results. Currently takes Accupril, 20 mg, BID (two times a day), Coreg, 25 mg, BID, and Doxazosin, 2 mg, daily. On 6/6/15, the faxed Physicians response stated - No changes. On 12/22/15 at 8:25 AM, Administrative Nurse A stated the resident is taking all three blood pressure medications because the physician was having problems regulating the resident's blood pressure. Administrative Nurse A further stated the physician ordered all three medications for the resident's blood pressure. The facility has physicians orders for all three medications. The 12/22/15 fax from Administrative Nurse A stated the pharmacy did not address the blood pressure medications.	F 428		

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F 428	Continued From page 63 The facility's pharmacist consultant failed to identify and address Resident #52's use of multiple blood pressure medications.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 64	F 441		

This Requirement is not met as evidenced by:
The facility had a census of 64 residents. The sample included 20 residents. Based on observation, record review and interview, the facility failed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection for all residents residing in the facility.

Findings included:

- On 12/16/15 at 8:20 AM, observation revealed Housekeeping Staff E put on gloves and entered Resident #2's room. Housekeeping Staff E used a duster and cleaned around the crown molding, above doorways, and dusted the edges of the ceiling in the bathroom. He/she moved the resident's personal belongings, with soiled gloves on, and dusted the corners of the room and bathroom. Continued observation on 12/16/15 at 8:26 AM revealed Housekeeping Staff E picked up trash in the bathroom, and moved the graduated cylinder (container used to measure urine) off the floor, and touched Resident #2's three drawer plastic cart and personal items on top with soiled gloves. Housekeeping Staff E used a rag with disinfectant and wiped down the paper towel holder, grab bars, moved the tooth brush and spit cup to a paper towel on floor. Housekeeping Staff E wiped down the top of the plastic cart with the same rag and moved the resident's personal belongings with soiled gloves. Housekeeping Staff E placed the rag in a container of disinfectant and changed gloves. Housekeeping Staff E put Soft scrub (cleanser with bleach) inside the sink, scrubbed with a small brush and rinsed the sink after

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approximately 2 minutes. Housekeeping Staff E mopped under the bathroom sink, picking up small pieces of debris, rinses his/her gloved hands and dries them with a paper towel. Housekeeping Staff E placed Resident #2's plastic cart and mesh laundry bag back under the sink, placed the graduated cylinder on another clean paper towel under the sink. He/she then used the toilet brush to clean the toilet flush lever, top of the toilet seat, inside the rim of the toilet, outside of the toilet bowl, and placed the toilet brush back into the plastic container. Housekeeping Staff E pulls up his/her pants with soiled gloves, then used Windex to clean the bathroom door mirror and room windows, he/she stated that he/she uses the same rag in several rooms to clean mirrors and windows. Housekeeping Staff E used the same rag from disinfectant container, wipes the wooden bathroom door, door knobs, and light switches. He/she then picks up trash can with trash in it, moves the resident's slippers, leg splints, and touches many other personal items with soiled gloves. Housekeeping Staff E used the contaminated disinfectant rag to wipe down the resident's personal figurines, the dresser, the cassette player, and touches the C-Pap tubing and mask with soiled gloves. Housekeeping Staff E, still wearing the same gloves, touched his/her face, then used the same disinfectant rag to wipe down the resident's mini refrigerator, desk, bed frame, head board, side rails, air mattress, and regular mattress. He/she then removes his/her gloves. Housekeeping Staff E put on new gloves and using the same disinfectant rag, wiped down the resident's personal wooden radio/record player stand,then moved his/her personal items.

On 12/16/15 at 3:45 PM Housekeeping Supervisor G stated that housekeeping staff are

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F 441	Continued From page 66 taught the guidelines of how to properly clean all the rooms in the nursing facility. After being told how Housekeeping Staff E cleaned Resident #2's room, he/she explained that he/she should have changed his/her gloves more often. On 12/16/15 at 3:00 PM Administrative Nurse F stated that most resident infections are acquired in the facility. Upon request a policy for infection control for room cleaning was not provided. The facility failed to provide a safe, sanitary, and comfortable environment to prevent the development and transmission of disease and infection for the 64 residents residing in the facility.	F 441		